

Instructions for ICARE Program Application

General Instructions: Please read all instructions carefully prior to completing this application and then, complete each section in its entirety. Complete one application (print or type) for each Kentucky Employer Identification Number (KEIN). If you have questions relating to the ICARE Program, please contact the Office of Insurance at 1-877-ICARE07 (877-422-7307). If there is insufficient space on the application for your response, you may complete the response on an attached 8 ½ by 11 inch sheet of paper and indicate the question number for which the attachment relates. Beginning with Page 1 of the application and for each subsequent attachment, it is requested that you label the page with your business name and Kentucky Employer Identification Number (KEIN).

NOTE: An ICARE Program participating employer is required to notify the Office in writing of any change in the information reported on the ICARE Program application within thirty (30) days of the change.

Section 1 – Employer Information

Business Name: Enter the legal name of your business entity.

Type of Entity: Enter the type of entity that best describes your business (e.g., Corporation, Foreign Corporation, Partnership, Individual {Sole proprietor}, Tax-exempt Corporation, or Tax-exempt Unincorporated Entity).

NOTE: Governmental entities are not eligible for the ICARE Program.

KEIN: Enter the nine-digit Kentucky Employer Identification Number.

SIC (Standard Industrial Classification Code): Enter the four-digit Standard Industrial Classification Code for your business entity.

Business Address: Enter the physical street address and P.O. Box (if applicable) of your business entity. This address should be the same as the address provided to the Kentucky Revenue Cabinet or Secretary of State.

Mailing Address: Enter the mailing address. If this address is the same as the business address, enter “same.” ICARE health care incentive payments will be sent to the mailing address of an eligible employer.

Contact Person: Enter the name of an individual who will serve as your business contact person for ICARE Program inquiries from the Office of Insurance.

E-mail Address: Enter the electronic mail address of the business contact person or “none,” if not available.

Telephone Number: Enter the telephone number of your business contact person, including the contact person’s extension.

Question 1: Enter the complete name of each individual who has any ownership interest in your business.

Question 2: Enter the total number of current full and part time employees at all business locations, including business locations inside and outside of Kentucky. Individuals with an ownership interest should be included in this number.

Question 3: Enter the total number of employees who are currently enrolled in your employer-sponsored health benefit plan **and** who are “eligible employees” under the ICARE Program.

NOTE: “Eligible employees” under the ICARE Program do not include:

- (a) Any employee who has attained age 65;**
- (b) Any employee who is Medicare eligible; or**
- (c) Any employee who does not meet eligibility requirements for participation in the employer sponsored health benefit plan established by the employer and insurer.**

Question 4: Check “Yes” or “No”, as appropriate.

NOTE: “Yes” should be checked only if the employer provided coverage under a comprehensive major medical plan. Health discount plans (e.g., discounts on services of physicians, pharmacies, dentists), limited health service benefit plans (e.g., vision, dental) or flexible spending accounts are not considered comprehensive major medical plans.

Question 5: Enter the complete name of the insurer providing your business with Qualified Health Benefit Plan coverage.

Question 6: Enter the name of the Qualified Health benefit Plan for which you have applied and been approved.

Note: All health benefit plans offered in the small group or employer-organization market are considered qualified health benefit plans. Previously uninsured groups with enriched plans will not qualify for the ICARE Program.

Question 7:

Enter the effective date of coverage for your Qualified Health Benefit Plan.

Question 8:

Check “No” or “Yes”, as appropriate.

NOTE: If “Yes” is checked, enter the name of the employer-organized association.

Section 2 – Employer Attestation

The employer must ensure that the employer group’s average gross annual salary does not exceed 300% of the current federal poverty level for a family of three. To calculate the employer group’s average gross annual salary:

- (1) Add the annual gross salaries of all eligible employees, excluding any employee who: (a) has attained age 65, (b) is Medicare eligible, (c) does not meet eligibility requirements for participation in the employer-sponsored health benefit plan established by the employer and insurer, or (d) has an ownership interest in the business; and
- (2) Divide this sum by the total number of employees whose salaries were used to calculate the sum of the annual gross salary. Review the information, requirements, and responsibilities of an employer as provided in Sections 1 and 2 and attest to the accuracy

of this information by entering your signature and date and by printing your name and title.

For example, an employer group has 10 employees of which 1 employee is an owner, 1 employee is age 67 and the remaining 8 employees are under age 65 and covered under the group's qualified health benefit plan. To calculate the average annual salary, add the salaries of the 8 employees and divide that sum by 8. If the result does not exceed 300% of the federal poverty level for a family of three, the employer group meets the salary requirements.

NOTE: For the most current federal poverty level information, you may visit the Office of Insurance website at: <http://doi.ppr.ky.gov/kentucky/> or telephone the Office at 1-877-422-7307.

Section 3 – Agent Verification

Question 1: Check only one (1) box.

NOTE: If an employer could qualify under both categories, and the employer elects to apply as a high-cost condition group rather than a previously uninsured group, the employer should be aware that he will become ineligible at renewal if the employer no longer employs an individual with a high-cost condition. For a list of ICARE high-cost conditions, see the Employee ICARE Program High-Cost Condition Certification on Page 6 of the application. For a list of enzyme deficiency disorders, which are limited to inherited metabolic diseases as established in KRS 205.560(1)(c), you may visit the Office of Insurance website at: <http://doi.ppr.ky.gov/kentucky/> or telephone the Office at 1-877-422-7307.

NOTE: (1) If the employer qualifies for the ICARE Program due to an employee with a High-Cost Condition (HCC), an ICARE High-Cost Condition Certification completed by each employee should be attached to this application. This certification must be distributed to and collected from employees in accordance with federal HIPAA privacy rules. Additionally, this employer group may be covered under a consumer-driven health benefit plan, a basic health benefit plan, or an enriched health benefit plan.
(2) If the employer qualifies for the ICARE Program as a “previously uninsured group,” the employer group may only be covered under a consumer-driven health benefit plan or a basic health benefit plan. A previously uninsured group is a group that has not been provided employer-sponsored comprehensive major medical coverage within the previous 12 months.

Question 2: Enter the group identification number assigned to this employer by the insurer that corresponds with the Qualified Health Benefit Plan on this application.

Review all application responses and supporting documentation, and verify the accuracy of this information by entering your signature and date, and by printing your name and DOI number.